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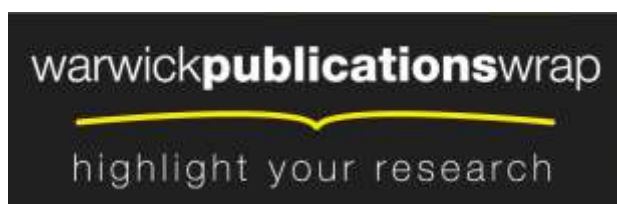
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22:5 Editorial

Rethinking Filicide

Peter Sidebotham

I had the privilege recently of attending an international conference on filicide hosted by Monash University. This conference, the first of its kind, attracted delegates from a diverse range of backgrounds and countries. The papers presented were of an exceptionally high quality, thought-provoking and challenging. We hope to publish some of these as a themed issue next year. One of the key themes to come out of the conference for me was the recognition that filicide (literally, the murder of one's own child) is not a uniform phenomenon, but rather, encompasses and overlaps with a heterogeneity of circumstances, characteristics and motives that result in fatal harm to children.

Currently there appear to be two main strands of understanding around filicide. The first, stemming from the work of Resnick in the 1960s, starts with the perpetrators, and their perceived motives. Resnick (1969) proposed a classification encompassing altruism, acute psychosis, the unwanted child, accidental filicide, and spousal revenge. Resnick's typology has subsequently been built on by others, including Dominique Bourget and Pierre Gagné, two of the conference speakers (Bourget and Gagne, 2002, Bourget and Gagne, 2005). The other main strand has come from the fields of paediatrics and child protection, and focuses more on the child as the victim and the circumstances surrounding the child's death. This strand, encompassing broader aspects of fatal child maltreatment and violence against children, can be seen in the work of Christoffel (Christoffel, 1984), Fujiwara et al. (Fujiwara et al., 2009), Reder et al. (Reder et al., 1993), and Wilczynski (Wilczynski, 1994, Wilczynski, 1997) among others.

Two of the papers in this issue pick up on the theme of fatal child maltreatment, approaching this within the two different paradigms described above. Emily Douglas (2013) reports on an online survey using a convenience sample of child welfare workers in the United States. This paper describes the case characteristics reported by 135 workers who experienced a maltreatment fatality of a child on their caseload. The paper gives some insight into common case characteristics; in particular, relatively high levels of parental mental ill-health, domestic violence and alcohol/substance misuse. Douglas also emphasises that other, wider characteristics are important, including parental unemployment; major life

events; and parents having inappropriate expectations of their child. In this study, there were very high levels of professional involvement with families prior to the child's death, reflecting the nature of the study; however, Douglas points out that, in spite of this, uptake of services by families was reported to be low. This may give some insights into those families most at risk of severe outcomes.

Lilian de Bortoli and her colleagues provide a thorough and helpful review of the literature on neonaticide (Bortoli et al., 2013). The authors draw primarily on the perpetrator-based work of Resnick and others, and outline some of the maternal characteristics and postulated motives. They extend this with a wider view of some of the background characteristics. This review provides some useful insights into what is known about this particular group of filicides, and picks up on some of the fear, shame and sense of being unable to cope (loss of control) that some of these women might feel.

In 2011, Marian Brandon and I, together with other colleagues, published a descriptive analysis of a cohort of fatal maltreatment cases (Sidebotham et al., 2011). In this, we proposed a five-fold typology within the child protection strand of understanding. We categorised cases as severe physical assaults; overt homicide; covert homicide and infanticide; extreme neglect or deprivational abuse; and deaths related to but not directly caused by maltreatment. This proved a helpful framework for exploring the characteristics of cases of fatal child maltreatment, but, like all typologies, had its limitations. Reflecting on the work being presented at the filicide conference, it seemed to me that the time has come for moving forward to a deeper understanding of filicide and fatal maltreatment that encompasses both strands of research, and that is focused on a more preventive agenda. A new approach to understanding filicide and fatal maltreatment would need to include five different elements (Table 1): the nature and circumstances of the child's death; the characteristics of the child as victim; the characteristics of the perpetrator; factors in the wider family and environment; and the provision of public and other services to the child and family. This framework encompasses an attempt to understand something of the motives of the perpetrators within a wider framework of perpetrator characteristics, and an ecological understanding of the child's world.

Table 1: Factors to include in an understanding of filicide and fatal maltreatment

Domain	Factors to consider
Nature and circumstances	Mode of death

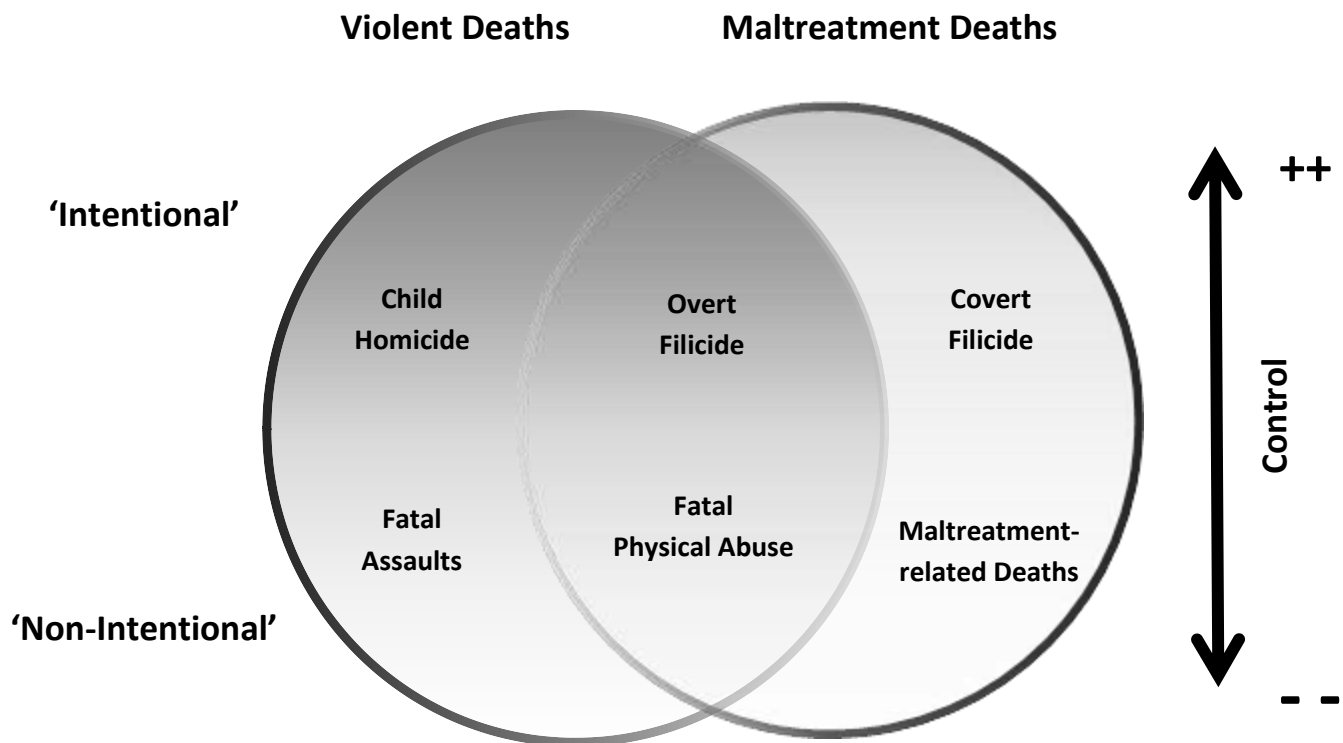
of the death	Use of overtly violent or other means Involvement of others (including other family members, pets, and attempted or actual perpetrator suicide)
Child characteristics	Gender Age Development Factors such as disability or temperament that may interact with the parents' care of the child
Perpetrator characteristics	Gender Relationship to the child Mental and physical health Background history, including domestic violence and alcohol/substance misuse Possible motives for the killing
Family and environmental circumstances	Family structure and functioning Parental separation or divorce Any precipitating or moderating events Social support structures
Service provision and need	Public and other service provision Any unmet needs of the child or family Response of agencies to any recognised risks or concerns

One of the fundamental difficulties in trying to understand motive is that often this is based on supposition. Even when perpetrators do admit to their acts, their ability to articulate and reflect on any underlying motives may be limited. It would seem, therefore, that we need to move beyond postulating about possible motives such as altruism or revenge, to consider more measurable components of observed behaviour. One element that seems to be frequently observed in different forms of maltreatment (fatal and non-fatal, physical and emotional, and against children and intimate partners) is that of control. This, in turn, potentially provides a more measurable perspective on perpetrator behaviour that could help in understanding how the range of circumstances in a family's life can lead to one member taking the life of another. At one extreme, we may observe a parent or parent figure who

displays excessive or disordered control: this may express itself through domestic violence, manipulation (even after separation), and ultimately exerting the most extreme control through taking another's life; or through distorted perceptions of attachment, and the perceived need to prevent separation or suffering in a child. These scenarios result in what might be categorised as more intentional filicide. At the other extreme, we observe parents or parent figures who lack control and respond to stressful events with violent outbursts, without necessarily any intent to harm, or whose lack of coping ability results in neglect or disordered parenting.

Pulling these different perspectives together, we can perhaps portray fatal maltreatment and violent child deaths as two overlapping circles: of maltreatment deaths (perpetrated by parent(s) or primary carer(s)); and violent deaths (using violent means). Superimposed upon this, we can add a spectrum of control, with a loose boundary between 'intentional' and 'non-intentional' deaths. This model provides six primary categories of violent and maltreatment deaths (Figure 1): 'overt filicide' where a parent or parent-figure in circumstances of excessive or disordered control uses violent means to kill a child (this may include the murder of other family members and/or the suicide or attempted suicide of the perpetrator); 'covert filicide', perpetrated by a parent or parent figure but with less overtly violent means, such as abandonment, or smothering, or deprivational abuse; 'child homicide', perpetrated by someone other than a parent or carer, again in circumstances of excessive or disordered control; 'fatal physical abuse', where a parent or carer with poor self-control kills a child in an impulsive violent outburst; 'fatal assaults', representing similar violent assaults, perpetrated by someone other than a parent or carer; and 'maltreatment-related deaths', where a child dies, through non-violent means, as a consequence of parental lack of appropriate care and control, through neglect, or other aspects of physical or emotional abuse.

Figure 1: The spectrum of violent and maltreatment deaths



As with all models, this will have its limitations. There may well be overlap between the categories, or a lack of clarity as to where any child's death might sit, something that may be captured by the blurred boundaries. It will need to be tested as a model, to see whether it is workable. And above all, careful consideration needs to be given as to whether it provides a helpful understanding of fatal maltreatment and violent child deaths that may lead to greater awareness and preventive action. It is important that our attempts to understand child maltreatment should keep a focus on preventing and responding to potential maltreatment, so as to protect children from harm. The paper by Lilian de Bortoli and colleagues demonstrates just such a focus. As well as exploring what is known about the characteristics of neonaticide, they review the limited literature on safe havens and other similar strategies for reducing the number of unwanted babies. While a number of countries have adopted such strategies, they point out that there is limited evidence of their effectiveness, and there are ethical issues to be considered in their implementation. Nevertheless, there is an imperative to identify and support families where a child is not wanted, for whatever reason, and to provide opportunities for the safe, nurturing care of those children.

Fatal maltreatment is, of course, the tip of a pyramid of child maltreatment, with much larger numbers of children experiencing non-fatal, but nevertheless damaging forms of abuse and neglect. This is reflected in the paper by Rachel Denholm and colleagues (Denholm et al., 2013). This team have prospectively studied a cohort of over 17,000 individuals born in a single week in 1958 in England, Scotland and Wales. Retrospective data on their childhood experiences were collected at age 45, and compared to prospective data on neglect collected at ages 7, 11 and 16. Between 14 and 17 percent of cohort members reported any form of maltreatment in their childhood, a finding that is broadly in keeping with other, more recent studies (Gilbert et al., 2009, NSPCC, 2011). Interestingly, they found higher rates of reported psychological abuse (10.0-12.5%) and lower rates of reported neglect (2.7-4.4%) than the NSPCC study (NSPCC, 2011). However, prospectively collected data using a range of indicators, showed a much higher prevalence of neglect (25.9–32.1 per cent having three or more indicators).

It is well recognised that self-reported and officially-recognised maltreatment tend to yield different data on the prevalence of maltreatment (Barlow and Calam, 2011, McElvaney, 2013), and this is highlighted in the paper by Ricardo Pinto and Angela Maia (Pinto and Maia, 2012). They simultaneously compared self-reports and official records in a cohort of 136 young people known to child protection services in Portugal. In only 17% of cases did the self-reports of maltreatment match those officially recorded. In others there was both under-reporting of officially recognised maltreatment (notably for physical neglect, physical abuse, and domestic violence), and under-recognition of self-reported maltreatment (particularly for emotional abuse and neglect). These findings emphasise the importance of not relying on a single source of information to understand maltreatment. Child maltreatment is more prevalent than is suggested by official figures of identified or substantiated maltreatment, and such data may not capture the reality of the child's lived experience. However, self-report may be affected by the way in which questions are asked, subject to recall bias, or influenced by a young person's perception of what is normal or acceptable parenting.

Two particular groups of child welfare professionals are the subject of two short reports in this issue. Karen McKenzie and Jill Cossar (2013) explore the perceptions of clinical psychologists about their role in child protection. In a questionnaire survey of 116 qualified clinical psychologists working in Scotland,

they found that only ten per cent reported that they had never dealt with disclosures of abuse and the majority, irrespective of specialty, had some involvement in most areas of child protection. A previous study by Rouf et al. (2012) highlighted some of the difficulties that community mental health workers faced in decision making around parenting capacity, so it is encouraging that McKenzie and Cossar found both a strong recognition of child protection responsibilities among their sample, and a high degree of perceived competence to meet those responsibilities. They highlight some of the skills that clinical psychologists feel they can bring to multi-agency working in child protection, and explore some innovative ways in which this might be achieved, while acknowledging some of the barriers to their effective involvement. One such initiative from Northern Ireland was reported in *Child Abuse Review* last year (Davidson et al., 2012): the Champions Initiative, identifying a Champion in each multidisciplinary community mental health team and in each family and child care team demonstrated a positive impact on interface working, although further work is needed to see if this translates to better outcomes for children and families.

The other group of professionals are staff on paediatric wards in hospitals. In a carefully reasoned paper, Alan Stanton and Robin Powell (2012) draw on case law and personal experience to highlight the inherent flaws in the use of Discharge Against Medical Advice (DAMA) forms within paediatrics. They argue that, where a significant risk of harm to the child through discharge has been identified, to allow the parents to take the child home against medical advice, undermines the safeguarding of children and offers only a false sense of security to doctors: 'If agreement cannot be reached and the child genuinely remains at medical risk,' they assert, 'it is hard to see the provision of a DAMA form as anything more than formalised collusion with neglect' (pXX). Their call for a ban on such forms on paediatric wards should be heeded by all hospitals.

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